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ABSTRACT

This report synthesizes the presentations and discussions from a 1993 symposium on comprehensive school health and safety into a blueprint for urban action. The first part of the report summarizes the nature of health and safety problems in urban schools and discusses some of the barriers that hinder integrated solutions. The second part describes some model programs highlighted during the symposium because of the comprehensive strategies they employ to address poor health, youth violence, or both. The third part lays out a working definition of a comprehensive school health and safety effort and its components. Essential elements of the blueprint include: (1) locally developed solutions, (2) community involvement and support, (3) interagency collaboration, (4) public education and awareness, (5) effective administrative structures, (6) true integration of activities, (7) a supportive school environment, (8) school-based services, (9) funding and resources, and (10) Federal support. (SLD)

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Caring Schools, Caring Communities: An Urban Blueprint for Comprehensive School Health and Safety

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National Invitational Symposium on Urban School Reform, Health and Safety

Convened by the
Council of the Great City Schools

with the
National Coalition to Stop Gun Violence

Sponsored by the
Centers for Disease Control

and the
National Association of State Boards of Education

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CARING SCHOOLS, CARING COMMUNITIES: AN URBAN BLUEPRINT FOR COMPREHENSIVE SCHOOL HEALTH AND SAFETY

Based on a National Invitational Symposium on Urban School Reform, Health and Safety

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THE PURPOSE OF THE SYMPOSIUM

The health and the safety of America's children, particularly those who live in inner cities, are being threatened in ways and on a scale almost unimaginable a decade ago. To address such problems as childhood HIV infection, epidemic gun violence, alcohol and drug abuse, adolescent pregnancy, and lack of primary health care, urban school systems are implementing a wide variety of programs.

Too often these programs are administered as separate efforts—distinct from each other, from the basic academic curriculum of the school, and from relevant services in the community. Urban educators recognize, however, that the health and safety problems threatening our children are not disconnected. These problems are intertwined with each other, with children's educational needs, and with broader social dysfunctions in the community. Addressing these problems effectively—taking good care of our children—calls for integrated, comprehensive reform strategies, developed jointly by schools and communities and by a range of relevant government agencies and divisions.

On December 12 and 13, 1993, the Council of the Great City Schools held a National Invitational Symposium on Urban School Reform, Health, and Safety in Washington, D.C. The symposium was made possible by a subgrant from the Centers for Disease Control through the National Association of State Boards of Education. The purpose of the conference was to arrive at some consensus about how health and safety issues can be addressed in an integrated way by urban school districts and communities—in other words, to develop a blueprint for urban action.

Assembled in roundtable were 54 people from the fields of urban education, municipal health, community-based organizations, law enforcement, nutrition, violence prevention, higher education, and government—the groups that will have to come together to make an impact on the problem. The Symposium combined opportunities for serious, sustained discussion among participants with presentations from people who had tackled health and safety issues from different and sometimes provocative angles. Although the discussion delved into some tough and distressing problems—with no shortage of controversy on such issues as the relationship between schools and police and the effectiveness of school-based conflict resolution programs—there were several areas of consensus, and these form the basis of this report.

This report synthesizes the presentations and discussion from the Symposium into a blueprint for a urban action. The first part of the report summarizes the nature of health and safety problems in urban schools and some of the barriers that hinder integrated solutions. The second part describes some model programs, highlighted during the Symposium, that use a more comprehensive strategy to

confront poor health, youth violence, or both. The third part lays out a working definition of a comprehensive school health and safety effort and the components that should be addressed in an urban blueprint for action.

The Council hopes that this blueprint will be useful not only to its member districts, but also to urban communities, other school districts, and anyone who cares about the wellness of urban children.

AGENDA

National Invitational Symposium on Urban School Reform, Health and Safety

Convened by the Council of the Great City Schools with
the National Coalition to Stop Gun Violence

Sponsored by the Centers for Disease Control
and the National Association of State Boards of Education

December 12-13, 1993

Holiday Inn Crowne Plaza Hotel
Washington, D.C.

Sunday, December 12

10:00 AM **Registration**

1:00 PM **Welcome and Introductions: Goals of the Symposium**

- Joseph Fernandez, President, Council of the Great City Schools
- Brenda Welburn, Executive Director, National Association of State Boards of Education
- Mike Beard, Executive Director, National Coalition to Stop Gun Violence

1:30 PM **Connecting AIDS, Poor Health and Violence in Urban America and Urban Schools: Nature of the Problem and Barriers to Success**

- Lloyd Kolbe, Director, Division of Adolescent and School Health, Centers for Disease Control
- Andrew McGuire, Executive Director, San Francisco General Hospital Trauma Center
- Shirley McBay, President, Quality Education for Minorities Network

Facilitator: Michael Casserly, Executive Director, Council of the Great City Schools

3:30 PM **Model Urban School Health Programs**

- School Barnhardt, M.D., Member, Seattle Board of Education and University of Washington Harborview Hospital
- James Williams, Superintendent, Dayton Public Schools
- Johnnie L. Fairfax, Executive Director, Comprehensive School Health Program, Washington, D.C., Public Schools

- Julio Almanza, Assistant Superintendent, St. Paul Public Schools

Facilitator: Jack Campana, Director of Health Services, San Diego Public Schools

5:00 PM **Preview of Council Town Hall Meeting on School Violence with CBS Evening News Anchor Dan Rather**

6:00 PM **Reception**

Sponsor: Honeywell Inc.

7:00 PM **Dinner on Own**

Monday, December 13

8:00 AM **Continental Breakfast**

8:30 AM **Predictors of Youth Violence and Model Urban School Prevention Programs**

- Daniel Webster, Director, Center for Injury Prevention, Johns Hopkins University
- Bruce Gill, Director of Training and Professional Development, Resolving Conflict Creatively Program, New York City
- Donald McElroy, Executive Deputy Superintendent, Portland Public Schools
- Luis Reyes, Member, New York City Board of Education

Facilitator: Ed Zubrow, Former Special Assistant to the Superintendent, Philadelphia Public Schools

10:00 AM **Role of Communities in Urban School Health Improvement**

- Ramona Edelin, President, National Urban Coalition
- Sherrye Phillips, Director, Healthy Choices for Kids

Facilitator: Rachel Hedding, Member, Rochester Board of Education

11:30 AM **Role of Communities in Urban School Violence Prevention**

- Al Dean, Executive Administrator for Training and Support Services, The Police Foundation
- Errol Henderson, Director of Violence Prevention and Peace Programs, Save Our Sons and Daughters (SOSAD), Detroit
- Franklin Tucker, Director, Barron Assessment Center, Boston

Facilitator: Sandy Horwitt, National Center to Prevent Gun Violence

1:00 PM **Lunch and Speaker**

Introduction: Joseph Fernandez, President, Council of the Great City Schools

- Peter Edelman, General Counsel, Department of Health and Human Services, and Chair, White House Task Force on Violence

2:30 PM **Merging Health and Safety Programs into School Reform: An Urban School Blueprint — Guided Group Discussion**

Facilitator: Joe Harris, McKenzie Group

4:00 PM **Adjourn**

THE CONNECTIONS AMONG HEALTH, SAFETY, AND EDUCATION

The Nature of the Problem

Consider how the following statistics are connected:

- In the Dayton Public Schools, only 35% of the children see a doctor regularly. As one urban educator noted, many children in inner city schools have worse medical care than children in Third World nations.
- Almost 1 in 4 school-age youth owns a gun. Somewhere around 100,000 students are carrying guns to school.
- 10% of children in New York City are not fully immunized by grades 7-12.
- 30% of 10-year-old boys and 60% of 10-year-old girls cannot do one chin-up.
- In 1991, there were 3,140 cases of AIDS in children under age 13.
- The proportion of the nation's GNP spent on health care has risen from 6% in 1965 to about 14% today, and is projected to be between 23% and 32% by the year 2020.
- 30% of children aged 5-8 have at least one risk factor for heart disease.
- In the United States, 52% of gun deaths are suicides. Teenagers, along with elderly white males, are the groups most at risk.
- 25% of children aged 6-11 are obese.
- 58% of the deaths of African American males aged 15-19 are gun homicides; these rates tripled between 1985 and 1990.

People may not tend to think about handguns as a health issue, or beer as a safety issue, but they are. All of these statistics, which were cited by participants at the National Invitational Symposium, are interrelated branches of a large and interconnected crisis in child health and safety—a crisis with deep roots in broader social problems of poverty, education, crime, and health care.

Because inner cities have concentrations of poverty, inadequate public health, stresses on families, and other factors, urban school children are especially threatened by this crisis. This is quite obvious to Symposium participants, who see children in harsh circumstances every day, at school, in hospitals, at community centers. But the wellness and security of children are not just urban concerns. As many speakers at the Symposium noted, gun violence, AIDS, teen suicide, child abuse, and other forms of trauma are affecting people in all types of communities

and circumstances. More Americans are beginning to realize that the state of the health and safety of school children is everybody's problem and everyone's national scandal.

Health and safety problems faced by urban children are related not only to each other, but also to demographic, behavior, education, and societal issues. It is a complex web of cause and effect, as the discussion at the Symposium revealed.

Connections to Risk Factors

Lloyd Kolbe of the Centers for Disease Control (CDC) described changes in health patterns and risk factors among the youth population and the American public.

In the age group 1-24, only four causes account for 75% of the deaths: motor vehicle crashes, other unintentional injuries (such as drowning, falls, or fires), homicides, and suicides. By applying a public health intervention approach, the nation has brought about reductions in the first two causes during the past decade. But the latter two causes have gone up. The situation is particularly alarming if one examines statistics for just the 10-14 age group, which has seen a 46% increase in homicide and a 75% increase in suicide.

Three basic types of risk behavior contribute to the vast majority of youth health threats, according to Dr. Kolbe: (1) drug and alcohol abuse, (2) fighting and access to firearms, and (3) sexual intercourse, which contributes to about 1 million teenage pregnancies annually, as well as HIV infection and other sexually-transmitted diseases.

The causes of death for the U.S. population as a whole are different from those for youth, Dr. Kolbe said, but are nevertheless applicable to youth health and safety education. Seventy percent of deaths for the U.S. population are attributable to three causes: heart disease, cancer, and stroke. All three of these adult causes are responsive to prevention, and all are related to certain risk behaviors, specifically tobacco use, poor dietary habits, and insufficient physical activity. CDC is collecting data on the incidence of youth and adult risk categories for every State and for 14 of the largest cities.

There are several things that urban educators should understand about these health risk behaviors as school districts undertake school health and safety programs. First, risk behaviors are usually established during youth, and often persist into adulthood. Second, the risk factors described above are all *preventable.* This suggests that if adults and peers can persuade students to stop engaging in risk behaviors or prevent them from ever starting, the nation will save a great deal in economic and human costs down the road.

A point raised several times during the Symposium was the risk created by the availability of guns. Several speakers advocated stricter controls on the manufacture and sale of handguns, assault weapons, or ammunition. As Mike Beard of the National Coalition to Stop Gun Violence explained, "If we keep trying to mop up after the action, it's an insane policy. If we try to turn off the taps, it's a policy that makes some sense."

Connections to Education

There are two-way links between health and education, as the Symposium discussion made clear. As educators see first hand, healthy children learn better. Healthy families support their children's learning better. Many of the factors that contribute to poor health, such as poverty and drug abuse, also contribute to low educational achievement. Stated more positively, a child who emerges from school with a good education is more likely to engage in healthy behaviors.

Connections to Other Social Problems

A range of social factors contribute to or reinforce poor health and violence in urban schools. The most notable, as pointed out by participants, are related to concentrations of poverty, including illness, a lack of primary health care, unemployment, homelessness, and mental health problems. Others factors mentioned included the rise in single parent families, lack of role models, lack of recreational and cultural outlets or other alternatives to the streets, racism, child abuse and maltreatment, and lack of prenatal, postnatal, and parenting skills. The concentration of all these factors in the inner city is further reinforced when parents abandon the urban public schools for suburban or private schools.

Health and safety can follow generational patterns. Unhealthy behaviors or poor parenting skills among adults tend to beget illness and violence in children. Drug and alcohol abuse among adults, for example, are heavily associated with domestic violence, child abuse, car accidents, and homicides. Particularly acute is the plight of foster children who, as one speaker noted, may have "never been raised by anybody"; 60% of the youth in prison come from the foster care system.

BARRIERS TO SUCCESS

Presentations and subsequent discussions at the Symposium highlighted the barriers that many urban systems face in trying to address health and safety problems in a comprehensive way.

Societal Barriers

How can we make inroads against school violence, participants mused, when

children live in a society that condones and even glorifies violence in countless conspicuous or subliminal ways—through television, movies, music, sports, advertising and more. How can we send an anti-crime message to youth when white collar criminals seem to "get away" with crimes, and elected officials show questionable ethics? These are the types of barriers that the society as a whole erects that make the job of schools harder.

Extreme materialism in society can be a factor. As panelist Dr. Errol Henderson of Save Our Sons and Daughters (SOSAD) said, urban children may try to appropriate a "Nike culture or Reebok culture" when they have lost touch with their real culture or with actual role models.

Other powerful interests in society send messages that run counter to health and safety. Some corporations promote poor health through the sale of products such as tobacco and firearms, in some cases targeting young people indirectly through sophisticated marketing. School districts must be particularly vigilant against "innocence by association," as Andrew McGuire of San Francisco General Hospital Trauma Foundation called it. This is the situation whereby some corporations try to co-opt the support of schools by contributing to worthy causes or funding education projects. One participant cited an example of a tobacco company that offered to pay for a new football scoreboard in her district.

In many communities there are still barriers against a full and realistic public discussion of problems related to prevention of sexually transmitted diseases and sex education.

Attitude Barriers

Commonly held attitudes can create barriers that inhibit action. One dangerous attitude is that of "it's not my problem." Often influential people who could make a difference do not take action because the problems of urban violence or illness have not seemed to affect them or their loved ones on a personal level. As Dr. Shirley McBay, President of the Quality Education for Minorities Network stated, "Until people begin to feel that acting on these issues is in their best interest, nothing really is going to be done about the problems we are facing." Recent highly publicized events of random violence may be changing this attitude, some participants noted.

Another attitudinal barrier blames the children alone for their own health and violence problems. While personal responsibility is necessary, it is too easy and very misguided to define health and safety problems as the problems of the children who make bad choices. Frequently one finds unhealthy parents and other adults making decisions about health and safety that affect children, setting poor examples, or

failing to provide essential prevention, care, and treatment. Children do not raise themselves; they are raised by others.

Some participants saw the "lock 'em up" attitude prevalent among the public and popular among politicians as a barrier. As Andrew McGuire contended, this approach has not been proven to be very effective; in fact, there is some evidence that prisons train young people to become more violent. In a training program run by McGuire's organization, participants initially advocated a prison solution, but the more they learned, the more they thought the answer lay with education. Peter Edelman, General Counsel of the Department of Health and Human Services made a similar point. "When communities get together, they may start by looking at tougher sentencing but they quickly realize they need to provide more alternatives for youth."

Gender-related attitudes create other barriers. Violence can be intensified, some participants said, by societal attitudes that condone the treatment of women as objects. Other speakers referred to the tendency to categorize violence as a "male" problem, and pregnancy a "female" problem, when either gender is involved in both. These attitudes can lead to ignoring violence problems affecting girls, such as female involvement in gangs, or date rape and friend rape; similarly, it can lead to de-emphasizing males as a target for teen pregnancy prevention and care programs.

Particularly insidious is an attitude that might be called the "fatigue factor." This occurs when members of the public, and even some educators, become tired of hearing about problems that seem overwhelming or intractable and respond by losing interest or hope. According to New York Board of Education Member Luis Reyes, the New York Board recently found itself fighting this attitude among a public tired of hearing about and dealing with AIDS—even as the rise in HIV infection calls for a redoubling of effort.

School System Barriers

School systems themselves can create barriers to success. One example is when schools see comprehensive health education as being in competition with other missions of school. As Dr. Kolbe said, and others agreed, health education is just as important as science or math education. "We think that at this point in history, by relegating health to a rainy day subject, we're giving a very implicit message to our young people that it's not as important as these other subject areas," he said.

According to Dr. McBay, schools may unwittingly employ educational practices that contribute to violence. Among these are an environment of low

expectations; adversarial relationships between students and adults in the school; racially-disparate attitudes among teachers, administrators, parents, and peers; a curriculum that includes few advanced courses; or practices, such as tracking, that reinforce rejection.

Dr. McBay further recommended that schools examine other policies that affect the overall school climate, such as whether they need more clearly defined discipline codes or dress codes; whether some urban high schools are too big, densely populated, and anonymous; and whether schools should stay open longer and be more available for community uses. On this latter point, some participants supported after-school programs that kept children in a safe place and offered such options as after-school homework tutoring or community education.

School systems may also erect barriers when they are overly concerned about positive public relations, to the point that they obscure the extent of the real problem or do not ask the community to help. Other barriers are created when schools do not practice what they preach; for example, when junk food sold in vending machines undercuts the nutrition education program.

Programs may also be hindered when educators feel that the problem is too big—that "we can't get our arms around it," as Ramona Edelin said. Young people can sense when teachers and others are afraid of the condition "out there" or have given up on them. A related factor is when teachers feel unprepared or uneasy about teaching some health-related subjects.

Funding Barriers

Funding problems are an important barrier to success. The situation faced by the Portland Public Schools illustrates how painful urban funding decisions can hamper a district's ability to provide even the most essential services. After voters defeated a state tax initiative, said Donald McElroy, Executive Deputy Superintendent, the district is going to have to cut $100 million from its budget over the next two years—one third of everything. Already the system has had to release 104 custodians, even though the district realizes that clean and well tended buildings can affect morale and student behavior.

The severe need for facilities improvement in urban districts has a bearing on health and safety, participants noted. Inadequate and outmoded facilities affect the physical and psychological well-being of students and faculty and may hamper districts from initiating school-based clinics or other services because they lack the appropriate physical space.

Other districts had other stories about funding barriers. In New York City, according to Luis Reyes, drug counselors are the only counselors in some schools,

taking care of all student counseling needs because schools cannot afford an adequate counseling staff.

A persistent barrier is the inequity in funding between urban school systems and other districts. According to one participant, a focus group of educators and community participants convened by the CDC to look at urban school violence issues concluded that when inner city schools are supplied and maintained as other schools are, many of their problems will disappear.

Districts that have a health program or school-based clinics often find that they generate a new set of funding demands for the health system as a whole. When health problems are uncovered, it is necessary to refer students for follow-up. It is crucial, said Oakland Board member Jean Quan, to have both the structure and the funding for followup, yet some districts have neither.

A similar dynamic may occur with certain efforts to reduce school violence. For example, the mandatory expulsion of students who commit certain infractions may highlight the funding inadequacies in the current programs for youth when there is no system in place to pick up the young people who are expelled.

DEVELOPING A COMPREHENSIVE REFORM STRATEGY

Connected Solutions

Currently most schools have separate programs for AIDS prevention and education, general health education, teenage pregnancy prevention, and violence prevention. Each program tends to have its own funding source, administrative requirements, curriculum, target audience, and constituency. But this approach has many drawbacks. Not only is it inefficient and potentially more costly, but it also flies in the face of what research and experience say about the connections between health and safety issues and the need to look at the child as a whole human being. "Fragmentation, segregation, isolation of different populations that we're concerned about only exacerbates their problems," said Ramona Edelin, President of the National Urban Coalition. "We've got to figure out how to put it all together."

The nature of health problems in the U.S. has changed so drastically that CDC—and participants in the Symposium—have come to believe that *comprehensive* school health programs are essential to improving health, safety and education. Having decided to move toward a comprehensive, integrated approach, school districts still must work out some complicated issues. How can programs with different funding sources and requirements be merged? How can they fit with the overall education reforms being undertaken in all the districts of the Great City Schools?

A particularly thorny issue to settle is how far the school's responsibility should extend for addressing all the problems of children. On one end, said Ed Zubrow, former Special Assistant to the Superintendent for the Philadelphia Public Schools, stand those who believe that the mission of the school is to teach cognitive skills, period. On the other end are those who believe that the school must "do it all." The challenge, he said, is to develop partnerships to address critical factors and to demonstrate the connection between responding to children's problems and advancing better education outcomes.

Because school funding is limited and so many of the contributing factors are outside of the school system, participants agreed wholeheartedly that the community must be involved. The specific mechanisms for doing this are discussed in greater detail below.

EXISTING MODELS FOR COMPREHENSIVE SCHOOL HEALTH EDUCATION AND VIOLENCE PREVENTION

Although the Symposium was predicated on discussing health and safety issues in an integrated way, the agenda included presentations on model health programs and model violence prevention programs, as well as model community efforts in each. These presentations were included as a way of highlighting some characteristics of effective approaches and discerning how they might be applied in an integrated approach. Both topics included discussions of the appropriate community roles.

DEFINING COMPREHENSIVE SCHOOL HEALTH AND SAFETY EDUCATION

The CDC has developed a definition of a comprehensive school health education program that is being used in several demonstration sites around the country. Some of the Great City School districts, including New York City and Washington, D.C., a participant in the CDC program, are using definitions that are quite similar. Based on these definitions, it is suggested that comprehensive school health education programs include the following components or variations thereof:

- Health education — offers a curriculum that includes instruction in such areas as human growth and development, community health, consumer health, disease prevention and control, environmental health, family life education, personal health and fitness, mental and emotional health, nutrition education, alcohol, tobacco, and other drug prevention, and safety, first aid and injury prevention.

- Health services — provides access to primary health care, prevention and control of communicable diseases, and emergency care for injury and sudden illness.

- Healthy school environment — ensures a caregiving environment, with clean, safe, and well maintained facilities and grounds, free of urban environmental hazards, drugs, and violence.

- Guidance and counseling — provides assessment, advocacy, and psychological counseling, referral to social services in the community, services to sensitize staff to students' cultural values, and services to ensure mental, emotional and social well being.

- Food services and nutrition education — provides healthy nutritional choices in school meal services, vending machine options, and fundraising activities; establishes health norms and model healthy nutritional behavior and opportunities for students to practice food selection skills.

- Physical education — provides organized activities to develop fitness and encourage lifetime physical activities.

- Employee health promotion — offers health services for faculty and staff; encourages staff to model healthy behaviors.

- Integrated school and community programs — promotes partnerships and involvement of parents, schools, and community agencies, working toward a common vision of healthy young people.

The CDC has also identified other characteristics inherent in comprehensive school health programs. They should be:

- planned and sequential;

- cover grades K-12;

- include integrated educational approaches to important topics; and

- be taught by individuals trained in health education.

Other Important Features

In addition to these basic components, other features were singled out by participants as being important to include in truly comprehensive programs. Several participants stressed the importance of beginning in the early grades, just as with math or other critical subjects. As Dr. Kolbe said, schools cannot expect to have an appreciable impact on student behaviors with a three-week health education unit in the 11th grade.

Another feature was an emphasis on prevention, which will save costs down the road. In fact, some noted, without major prevention efforts, health care will become even more of a major economic problem.

Luis Reyes presented seven aspects of prevention education in *New York City*, the seven "C's":

- condom availability;
- community education and dialogue, including community forums with updates on AIDS transmission and the nature of the epidemic;
- confidential counseling and testing with referral to medical and support services;
- curriculum that is age-appropriate, developmentally appropriate, and factually accurate;
- cultural diversity in the curriculum, including provision of bilingual and native language information and outreach;
- collaboration that encourages and strengthens links between schools, the board of education, community-based organizations, health agencies, and health service providers; and
- census data on progress and cases of diseases.

Another feature programs should incorporate is the expectation that students would change their behavior. Educators can help in this process by providing information on the consequences of high risk behavior for violence and illness.

Dr. Barnhardt emphasized the need for adequate funding for screening and surveillance of transmissible diseases, particularly tuberculosis which is reemerging in low-income populations.

As to the specific content of health education, important topics to be included, participants felt, are education about human sexuality, HIV/AIDS, and other sexually transmitted diseases, education about nutrition and dietary patterns contributing to disease, the importance of physical activity, sedentary lifestyles, the hazards of tobacco, alcohol, and other drugs, first aid, CPR, and safety techniques, and strategies for coping with life situations.

Not to be overlooked is the need to teach young people—both those who are parents and those who are not—about child development and responsible parenting. Several successful urban programs attest that this type of instruction is effective in reducing pregnancy and child abuse.

Evaluation and accountability are critical aspects of comprehensive programs. Too often public institutions judge the success of their efforts based on whether they have established a process, not on whether they have produced outcomes, said Joe Harris of the McKenzie Group. School districts should choose measurable outcome goals that can be evaluated. They should use the results of evaluations to redirect resources to areas of needs.

HANDLING CONTROVERSY

Putting in place a comprehensive health education program, school districts are bound to enter into controversial areas that must be handled delicately. Among them are issues of terminology, condom and other birth control availability, frankness and completeness of discussions about sexual orientation and sexual intercourse, and the age at which particular topics should be introduced. While some participants felt that schools should not shy away from the tough issues only because they might be politically difficult, there was a clear understanding that the attitudes of the community would have to be addressed. Parent education and training was recommended to smooth these discussions. Support by key community leaders can also help.

In some communities the location of clinics in schools has become a controversy, because they are often associated in the mind of the public with issues of sex education, condom availability, and birth control, although they provide much more. School districts have taken different approaches to these controversies, depending on the strength of community support or opposition. In *Dayton*, for example, Superintendent James Williams said the school system attempted to defuse some of this by calling their in-school services "wellness centers," rather than clinics. In Seattle, the school-based clinics do not provide family planning on site (although condoms are available) but refer students to local family planning with parental permission. This approach has been well accepted, said Dr. Barnhardt.

MODEL SCHOOL HEALTH PROGRAMS

Begun in 1992, *Seattle*'s program of school-based clinics is a joint venture between the school district and the local health department. The program is funded through a special "family education levy" earmarked for child health and safety and early childhood education, Dr. Barnhardt explained. Much is riding on the success of the endeavor, for the city must go back to the voters for approval in 1997. The school district laid the groundwork for its school-based clinic program by promoting and marketing, making sure that students knew the services were accessible.

The clinics, which are primarily in high schools, are operated by local health care providers, and this aspect has proved quite successful. Care is taken to ensure that staff are cognizant of cultural diversity. Seattle also offers a coordinated K-12 health education program covering most of the major health risk factors. One unsolved problem is what to do during summers, weekends, and evenings, when the school clinics are closed.

The *Dayton Public Schools* has a comprehensive school health education program begun through a 36-month grant from the U.S. Department of Education

as well as a Kindergarten initiative. Both were begun in 1991. The Federal grant for the comprehensive school health program ended in August, and this has reduced the funding available to train all elementary staff to implement the curriculum. Where possible, comprehensive health has been infused into the curriculum in areas such as math, science, language arts, and social studies.

A goal of the comprehensive health program is to co-locate county services on site. The district operates "wellness centers" in four high schools through a collaboration with community health agencies.

According to Superintendent Williams, the district decided to focus on the Kindergarten level because of its belief in the early intervention approach. The majority of health funding had already been at the high school, and there was a great need at the elementary level. The goal is for every child to have a physical examination every year. A key feature of the program is screening and follow-up for vision, hearing, and dental problems.

Dr. Williams attributes some of the success of these initiatives to the involvement of staff people from key social services agencies. After receiving from the school district a list of needed services, the community social service organizations divided up responsibilities for providing various services among themselves. Community volunteers are also important; for example, 380 dentists volunteer one day a year to the program.

Dr. Williams also stressed the necessity of moving away from a caseload management model toward one where people are responsible for providing direct services, not just following or managing services.

The *Washington, D.C.* Public Schools have a CDC grant for a comprehensive school health demonstration program. The program is a five-year collaboration between the school system and the commission of public health and is operated in five sites in the District. Its purpose is to develop and strengthen school health programs to prevent health risk behaviors, including prevention of injuries through handgun violence. The philosophy behind this program is to infuse health education into the overall school curriculum. School-based health services are provided.

The *St. Paul Public Schools* offer primary and preventive services to high-risk children through school-based clinics in five high schools. The clinics provide health services and day care, with many services provided by school nurses. Some of the services are reimbursed by Medicaid, an important funding source. Pursuant to state mandate, early childhood health and developmental screening is provided to all children before starting school.

A looming issue is whether St. Paul will be able to keep its school nurses in the face of budget cuts. The health department has approached the district about contracting out these services, but the district feels that school nurses are one of best bridges to reach students and determine who is at risk. The message here, noted another participant, is not to overlook what the traditional school health care providers can contribute.

New additions to the school-based clinics in the *Philadelphia Public Schools* provide mental health services as well as primary care; in one instance, a clinic located in a school building will serve community residents as well as students.

Jack Campana, director of health services for the *San Diego Public Schools* outlined some common threads of effective school health education programs pertaining to the role of communities. First, school health is seen very much in the context of the community, with strong links to social services and public health. Second, families are recipients and supporters of programs. Third, and most important, local community-developed models work best in a given area.

The Symposium also included programs developed by groups outside the school system. The California Wellness program, described Andrew McGuire, included a multi-pronged approach: policy development to work on behalf of gun control legislation, a trauma foundation that makes grants to community coalitions for locally developed youth violence prevention programs, provision of advocacy skills training for community collaboratives, leadership development, and research programs.

Presenter Sherrye Phillips, Director of Healthy Choices for Kids, illustrated a role that the private sector can play in health education. With sole funding from the growers of Washington State apples, a nutrition education curriculum was developed for grades 1-5. Healthy Choices for Kids is the first nutrition program based on the 1990 USDA national nutritional guidelines. Materials are provided free to schools and focus on giving teachers and parents techniques for encouraging children to try nutritious foods and pay more attention to healthy eating.

MODEL SCHOOL VIOLENCE PREVENTION

Do school-based conflict resolution programs work? This was a hotly debated issue during the Symposium, as representatives of school violence prevention programs contended they made a perceivable difference, while Daniel Webster, director of the Center for Injury Prevention at Johns Hopkins University expressed skepticism about their effectiveness based on a review of research data. School-based conflict resolution programs try to teach students to resolve problems through nonviolence, said Dr. Webster, by presenting them with options for avoiding risk.

Although these programs are intuitively appealing, he said, there is no clear evidence that they actually change student behaviors, at least in terms of the number of gunshot traumas.

One evaluation of programs in the late 1980s showed no significant improvement in attitudes about violence, acceptance of violence, self esteem, fighting, weapons carrying, or drug abuse, he said. Another study in a different city found some small gains in students' ability to define the problem of violence and their attitudes about aggression as a way to solve problems, but no change in weapons carrying or use of nonviolent solutions. One program that showed possible benefits was more intensive than the others, which tended to be superficial.

School-based conflict resolution programs are also based on some questionable assumptions, he said. First, they deal with all students' problems of violence in a blanket fashion, although students become violent for many different reasons at different times in their lives. Second, they assume that students who perpetrate violence are deficient in other social skills, which is not necessarily true. Third, there is no persuasive evidence, in Webster's view, that the causes of some adolescent violence, such as challenges to masculinity or respect, fit a negotiation model. Finally, classroom based programs have not shown an effective record of changing behaviors for other adolescent health problems.

Perhaps the most dangerous aspect of these programs, Dr. Webster argued, is that they provide political cover for politicians and school officials, who can appear to be taking action without addressing serious but more politically controversial systemic problems, such as gun control. He also expressed skepticism about the efficacy of giving students information without changing the other circumstances in their lives that contribute to violence.

Bruce Gill, representing *New York City's* Resolving Conflict Creatively Program, disagreed with Webster's assessment, noting that according to an external evaluation of the program, the great majority of teachers observed clear differences in student behavior and declines in the number of fights. Students said the program helped them address problems, and principals said it affected the number of violent incidents. The program also reduced the number of suspensions and improved feelings about school climate, noted Council President Joe Fernandez.

The New York program, now in its eighth year, is in 180 schools. The program is not just an add-on to the curriculum, but rather looks at schools as complex organizations, with particular attention to the relationships between students, teachers, parents, and the community. The orientation is not to blame all the problems on the students, but to view the problem as one shared by the whole community. In fact, said Gill, the New York program uses conflict resolution as a

way to change the entire school environment and promote total school reform, by building a critical mass of teachers, parents, and students who are changing the school. Teachers and administrators are provided with ongoing training in leadership skills.

The program includes more than conflict resolution, said Gill; it also deals with values, critical thinking, and awareness of alternatives to violence. The program is trying to have a faster impact by doing three things at once: curriculum change, parents' workshops on peace in the family, and a peer mediation component, whereby students receive training to mediate conflict with their peers. One participant said that her district pays students to serve as peer counselors, after providing them with training; these are students who need the money and likely would have worked after school.

Luis Reyes, also of New York City, outlined an eight point program for violence prevention in the public schools that included a school safety hotline, a clergy advisory council, a crime prevention council and newsletter informing students, teachers, and parents about prevention techniques, a guns in school tip line, a parents' school safety advisory group, a training program to teach parents and students safety and defense strategies, after-school athletic programs, and a national council on school safety.

Other speakers concurred that in-school violence prevention programs can play a critical role, especially if they are longer- term programs rather than a short-term curriculum add-on. Some programs highlighted at the Symposium, for example, use conflict resolution as a vehicle for addressing schools as complex organizations, encouraging administrators and faculty to examine the relationships, conditions, and policies in their schools that work for or against violence. Another approach is to develop a community-wide prevention effort, in which school-based programs are just one of many components.

Many speakers recognized that school violence prevention programs do not obviate the need for broader societal solutions. As Rachel Hedding of Rochester Public Schools noted, "I see the conflict resolution that we're doing in our system as putting out a small brush fire while it's still raging. We're doing that to exist, to get through the next day, to help those few kids that we can help."

And as Ed Zubrow observed, some young people are so estranged from traditional, middle class values that they cannot be influenced in conventional ways; creative models must be developed to teach not only the skills for resisting violence but also some persuasive reasons why to resist.

Another opinion was expressed by Mike Beard, who felt that some politically popular approaches to school violence, such as eliminating school lockers, were

ineffective, resulting in time wasted and loss of lives while more lasting legislative changes were pursued. Dr. Edelin expressed a similar concern that the "hardware people" will profit from the current crisis, through sales of bullet-proof vests, metal detectors, and other equipment, when a more effective approach is to fund grassroots community movement organizations.

COMMUNITY ROLES

Several participants and speakers also addressed model projects and strategies for community involvement in school health and safety programs.

Ramona Edelin spoke of an Urban Coalition project to recreate neighborhoods into villages that will raise children in a nurturing environment, providing education and job training. Part of this project is to involve businesses with roots in the community as anchors that will hire and train young people and help them become self sufficient.

The project, which is just getting underway, will have a residential component for nonviolent first time offenders, runaways, school dropouts, and foster care children. The residential schools will offer graduation credits in a positive educational and developmental environment, not a boot camp environment. Also part of the scheme are twenty-four-hour family centers that will offer cultural activities, recreational activities, music and dance lessons, sports, and other positive and motivating activities. The ultimate goal, said Dr. Edelin, is to create "a successful urban eco-system."

One such grassroots movement is the creation of parents affected personally by youth violence. In *Detroit*, SOSAD is a grassroots nonprofit organization established by the mother of a murdered son to teach peace and peacemaking skills. Dr. Errol Henderson of SOSAD described the group's programs, which include counseling and training in violence prevention, crisis intervention, multicultural conflict resolution, gang redirection, and peer and bereavement support. At the heart of the program is the concept of youth teaching other youth. The program trains young people to become involved in peace activities, which have a multicultural focus.

"When you have 12,352 homicides [as in Detroit], you have a city that is grieving; the whole city is traumatized," Dr. Henderson maintained, and healing this grieving community requires community-based solutions. In fact, he contended, action will be taken when the community demands it.

Dr. Henderson had several recommendations for making community-based violence prevention programs work. First, he said, programs must be individualized

to the community. Second, it is important to work with gangs, because that is who the young people respect. Third, groups should not write off older kids, for often they greatly influence their younger siblings.

In *Boston*, students caught with weapons in school are sent to the Barron Assessment Center, directed by panelist Franklin Tucker. At the center, where the average stay is about ten days, students do their academic work and receive credit for school attendance and also receive counseling. The center program has only a six percent recidivism rate, and often acts as an advocate for students in their dealings with the courts and school officials.

In Mr. Tucker's view, most of the youth who come to his center are scared. Many join a gang because it gives them a sense of security and caring that they do not get elsewhere; many will respond when they see that somebody else cares and that other options are available. Mr. Tucker told an anecdote of a gang leader who turned away from drugs and the gang when Mr. Tucker, after great effort, was able to help the youth find a job with a moving company, which was something he wanted to do. "If you offer them options, and you show them that you're sincere," he said, "and you show them that you're trying to help undo some of the things that have been done and show them a new life, they'll come around. There are a lot of kids out here just starving and waiting for attention."

Some discussion centered around the fears that students have about their safety in their own neighborhoods, which leads some students to the erroneous conclusion that they must carry guns to protect themselves. Dr. Henderson said that his group tells students that if they feel they cannot go to school without gun, better not to go, and then work with parents and students and schools to make a better school environment.

A different view was espoused by Al Dean, Executive Administrator for Training and Support Services, The Police Foundation. Mr. Dean recommended that schools take a variety of "proactive" measures to respond to school violence, including the establishment of better cooperative relations with local police, and police management of school security efforts. Serious crimes need to be dealt with by people trained in crime prevention and control, he maintained, which school officials are not. The greatest obstacle to school safety, he contended, were school administrators who were not open to critical review.

Mr. Dean's recommendation for police management of school violence prevention efforts met with disagreement from several participants, who stressed that students, and sometimes the community, see police as part of the problem. African American and Latino communities in particular are sensitized to police brutality issues and do not trust police to handle child safety, noted Mr. Tucker,

agreeing, however, that school officials needed to be trained better. Mr. Dean also stressed the importance of cooperative linkages between school, community, and police as an effective strategy to reduce school violence.

One project that piqued participant interest was described by Patricia Newby, assistant superintendent, *Baltimore City Public Schools.* The Community-Building and Partnership Program is a community developed venture in the Sandtown-Winchester neighborhoods of Baltimore, an area with high crime rates, major health problems, and a high infant mortality rate. The community itself set goals from the grassroots level for this 17-square block neighborhood in the areas of education, housing, law enforcement, health, youth programs, recreation, and public safety. The development of goals was a two-year process, and now the community is working with all key city and community agencies to implement the goals through a ten-year plan funded through various means, including the City, the Public Schools, foundations, HUD, the State, businesses, and community agencies.

Among the strategies for reducing violence in Sandtown are community education programs, safe houses, foot patrols by police, and community members' patrol for truants. School readiness and child health are other key concerns of this project: community members conduct a house-by-house canvass of three- and four-year-olds. A program for pre-natal and zero to three-year-olds has decreased the number of infant deaths and disabilities. Under the school district's "New Compact Schools" approach, the community is taking responsibility for readying these children for school; in turn the school makes a compact to move the children effectively through the system with new and very focused and innovative programs after they arrive. The health department is working to get health clinics in the three elementary schools.

Said Dr. Newby, "There are a lot of people who are interested in what's taking place in that little community because for the first time we're not doing education over here, health and safety over here, and housing over here. Everything is happening in that 17 square block area."

ELEMENTS OF THE BLUEPRINT

From the presentations and discussions of the Symposium, a blueprint began to emerge, consisting of broad steps that urban school systems and others could take to implement effective, comprehensive programs for health and safety. This blueprint is not meant to be an iron clad program, but rather to provide generic suggestions that could offer a sense of direction or a framework as districts and communities develop their own plans. As Dr. Henderson noted, there is no "one size fits all" solution.

From the discussion emerged a consensus that the following elements should be part of an urban blueprint.

1. Locally developed solutions

Each community must design a comprehensive health program that includes a unique combination of approaches to provide the services the community decides it needs. Several of the model programs discussed at the Symposium were based on a local needs assessment done by schools and community groups or councils, sometimes working in concert with social service or public health agencies. Often a school-level planning process is useful, too. A next step might be an inventory of community services that are already available from various sources.

2. Community Involvement and Support

If one message arose clearly from the Symposium, it was that community involvement and community leadership were critical to the success of a comprehensive school health and safety initiative. The problems of school health and safety are too intertwined with the larger social context, the need for community support on controversial issues is too great, and the contributions that can be made are too important to omit this feature. Sometimes the school district is the party that reaches out to the community, inviting their involvement through policy councils or advisory boards (see item #3 below). In other cases, the community comes to the school with the will to act and, perhaps, a promising strategy originated at the grassroots level.

The key to creating a successful community alliance, Dr. Edelin asserted, was to provide people with a vision and a project to accomplish together. "Coalitions come together by doing something together," she said.

In this context, community should be defined quite broadly. The particular players will vary by community and may encompass neighborhood residents, community-based organizations, parents, clergy, community agencies and service providers, elected officials, fraternities and sororities, law enforcement, business people, and the general public.

Involvement of the community also may be fostered by the school providing direct funding to community-based organizations to carry out a violence prevention program or an aspect of a comprehensive health program. As Dr. Edelin pointed out, a myth has been perpetrated, often by those who want to cut funding for a program, that good ideas are bound to sprout when federal seed money is distributed directly to the grassroots level. This myth overlooks the importance of high quality technical services and support to help grassroots reformers implement their good

ideas. A community group with expertise can play that intermediate role effectively, Dr. Edelin said.

As regards which community groups to fund, Dr. Henderson said, "We have to target those organizations that have an agency aspect and a movement aspect. These aren't just created. They're not created over patronage, they're not created over top-down approaches; they're created from grassroots initiative."

Working out relationships between grassroots organizations and schools can be a delicate proposition, many participants noted. School people sometimes must take risks to work effectively with community-based organizations. There may be disagreements between CBOs and schools, but the relationship does not have to become adversarial. Some realizations must occur on both sides, however. The school must recognize that community groups can do some things better and that it is not necessarily an admission of failure on the school's part to bring in some services from the outside. Similarly, community groups must recognize that they do not have expertise in everything and that schools are a very important part of the community—in some cases, the last unifying institution in a deteriorating community.

Participants from Pittsburgh and Dayton described problems they encountered when each district participated in a community linkages demonstration program funded by the Annie E. Casey Foundation. Each community received $20 million—$10 million from the foundation and $10 million in private matching funds raised locally—to be used to coordinate educational and social services. The main problem, said Dr. Williams of Dayton, was an attitude on the part of the social services agencies that their mission was to "fix" the schools. The community council that made decisions for this program kept changing the program when the problems did not respond quickly to one type of "fix," and before long the business sector lost confidence and withdrew their support. Both Dayton and Pittsburgh representatives said that they learned from the experience. Dayton learned to involve the right people from social services in a coalition—the staff people who provide the actual services, not the agency CEO, Dr. Williams said. Pittsburgh learned about the importance of having a community "buy in" and responding to the needs the community decides are most critical, said James Cusimano of the Pittsburgh Public Schools.

The contributions that private businesses can make should not be overlooked, said Sherrye Phillips. For example, she said, to initiate the Healthy Choices nutrition education program in a new community, her organization solicits involvement of local grocery stores, who can provide resources, equipment, technology, a public relations network and media contacts.

3. Interagency Collaboration

A consensus also emerged from the group that a comprehensive school health and safety program brought together services from a variety of education, health, and social service agencies in the community. Sometimes the services were co-located in the schools or nearby centers, sometimes they were not; the important feature was to have a joint administrative structure or conduit for bringing various services to the children and families who needed them.

To accomplish this, participants felt it was important to bring key stakeholders around the table—including health and social service agencies and providers, community-based organizations, school people, foundations, universities, municipal services, and others—to form a policy group that can assess needs, set an agenda, and develop a strategy for implementation. Dr. Johnnie Fairfax of Washington, D.C. used the acronym "PACTS" to identify the stakeholders he felt were absolutely critical in any collaborative process: Parents, Administrators of relevant agencies, Community members, Teachers, and Students.

Universities were also felt to be important partners that should not be overlooked, particularly their schools of education and of public health, nursing, medicine, and social work. Encouraging a multidisciplinary approach among these departments at the university could help when professionals from different fields seek to integrate services in their jobs. Developing urban internship programs for prospective teachers and professionals in other fields is another option.

This roundtable process may not always be pleasant—as Mr. Cusimano said, sometimes people need to be given an opportunity to vent frustrations—but in the long run it will be rewarding. If possible, existing policy groups for separate programs or initiatives should be combined into one such group.

Care must be taken, said Ed Zubrow, that collaboration is more than just a "glow word," describing a goal that makes people feel good when talking about it but fails to address the practical changes that must occur to make it a reality. Several participants felt that collaborative groups are most effective when they include the staff people who actually provide education or social services. "The closer you get to the people that are really seeing problem, the more likely the problem is to be solved," said Rachel Hedding of Rochester.

Should schools be the lead agency in this type of collaborative? Dr. Williams said, Definitely yes because schools are where the children are. Dr. Williams also felt that the process worked better if critical people were on the school district's payroll; he gave the example of a social service linking experiment in Dayton in which the social service people and the school people did not work together effectively, in part because of different philosophies, different work schedules.

In some cases, Luis Reyes observed, it may be necessary for the school district to provide leadership when members of a collaborative or council do not agree on controversial issues, such as HIV/AIDS prevention, yet the community cannot afford to do nothing while a policy making group is stalled.

To arrange for services from the community, some school districts use a community agency as a "broker," or facilitator; this organization, which might be a group like the local United Way or a grassroots organization with a strong track record and support, would arrange for access to other community services, either through the schools or within the schools. Each agency or community group would do what it does best. As facilitator Joe Harris said, it does not matter if the community has 10 or 100 service programs if school children do not have access to them.

4. Public education and awareness

A public education effort is needed to introduce a comprehensive health and safety effort or corral support for the steps to solve epidemics of disease or violence. In fact, as many participants noted, when the mass of public concern builds—spurred by a grassroots organization, media coverage of events, or perceptions that enough is enough—things tend to get done.

Andrew McGuire offered the analogy of Mothers Against Drunk Driving, an organization that he helped to launch by serving on the original Board of Directors. He credits MADD with helping to turn public opinion away from a tolerance of drunk driving or a perception that it was a problem to be dealt with by the criminal justice system; as a result public attitudes about drunk driving have changed and fatalities from this cause have decreased. Gun violence is a public health problem of similar magnitude, McGuire said. He believes that public opinion is shifting and the climate is ripe for a grassroots movement of people affected personally by violence. Mike Beard similarly recommended a massive public education campaign, similar to a Surgeon General's anti-smoking campaign to alert more people to facts on gun violence and help them understand that it is a not just a problem of isolated areas or inner cities.

In mounting public awareness efforts on health and safety, school districts will have to talk candidly about the extent of the problems and, in some cases, their own weaknesses in dealing with them effectively. Frank public discussion of issues that some parents would prefer not to have aired is also necessary. While an effective public awareness campaign will turn up the heat for the district to do something, it can also build the support and cooperation necessary to take the difficult steps. Building voter awareness, especially among parents, can also help garner political support for progressive leadership among elected officials and for tax levies to pay

for comprehensive programs. Businesses that are vested in the city and community can also help.

The media, sometimes perceived by districts as a hindrance, can become an important ally in public education. As Peter Edelman said, schools work with larger coalitions on a local or national level to urge the media to reduce violence in television, films, and recordings and to send more responsible and affirmative anti-violence messages. Pro-health coalitions can also try to persuade major corporations to cease any appeals to young consumers for such products as beer and tobacco.

5. Effective Administrative Structures

Implementing a comprehensive health and safety program requires leadership and effective administrative structures to contend with problems that inevitably will arise.

Several districts with experience in comprehensive programs recommended that a comprehensive school health coordinator or leader be hired or appointed, a person with enough power in the school system or community to negotiate across all parts of the service network. Several districts have assigned responsibilities to a special assistant to the superintendent or an assistant superintendent who reports directly to the superintendent. Part of the responsibilities of this person should be to deal with community organizations and city agencies and become aware of the full range of services and expertise available in the community.

Similarly, the CDC demonstration program provides funding for chief state school officers to hire a person to work at the highest levels of the state department of education, deal with the legislature, bring together resources, and work across all eight components of a comprehensive school health program. The CDC effort recommends a parallel position be established by the state health commissioner. As Dr. Kolbe observed, if the responsible person is buried in the bowels of an agency, he or she will not have the authority to address important policy issues. Based on the Symposium discussion, this seemed to be a relevant model for an urban district as well as a State.

Another is assignment of a few committed individuals to follow through, or a team of people working in areas of specialty.

6. True Integration

As noted above, a problem with many good existing programs is that they do not connect with each other or with the basic curriculum of the school district.

Sometimes this is a consequence of the categorical nature of the funding

sources for specific programs. Ideally, Symposium participants recommended blending existing monies from different federal, state, local and private sources into an integrated program; for example, using funding from a federal drug-free schools grant to support the alcohol and drug prevention education activities under a larger, comprehensive effort. Where program regulations discourage this type of melding, the district may have to pursue waivers or advocate for more flexibility in future legislation.

In some cases, a single topic program can be used as a springboard to developing a more comprehensive effort. Dr. Kolbe gave the example of a CDC program for HIV prevention, treatment, and education. A purpose of this program is to improve the infrastructure for delivering HIV services in a way that could also be used for other categorical health services. Moreover, the research system that CDC is trying to develop to identify the most effective HIV programs and move them quickly into the field could also be used to disseminate other information.

7. A Supportive School Environment

The effectiveness of a comprehensive school health and safety program often depends on whether complementary changes are made in the school environment. As Ed Zubrow said, "The school itself is a complex community. How do we change our own community?"

These changes may take a variety of forms and will vary by school building: from changing the roles of existing school nurses or counselors, to stocking vending machines with fruit juice, to requiring students to wear uniforms. A consensus also emerged that the students themselves needed to be involved in developing particular solutions.

Many Symposium participants felt that it was absolutely critical to develop alternatives to expulsion for students with disciplinary or violence problems, as well as alternative academic programs for students who are not achieving or learning in the regular class environment. Stricter expulsion requirements will not solve the problem, several felt; instead they will put more youths on the street with little to do, where they can still influence their peers. One district cited at the Symposium had developed a military-type academy as an alternative. Another participant described a program operated by Historically Black Colleges and Universities for students with low grade point averages. Still another advocated expanding preschool education, or adding a 13th year of high school for those students who need a bridge and special support to prepare for technical school, community college, or four-year college.

Gaining the support of teachers for reform and providing professional

development to teachers were also cited as important steps to create a positive school environment. As one participant noted somewhat wryly, school districts should also be concerned about the health of the teachers who must carry out comprehensive health and safety programs. Sometimes they feel as if they are not adequately prepared to do all that is being asked of them. This also has implications for urban schools of education.

8. School-Based Services

Schools are often the largest agency in the city, and the only one that interacts with nearly all children and looks at all the needs of the child. For these reasons, participants felt that some type of school-based health and safety services were an important feature of a comprehensive programs. As one said, "You must bring the doctors to the kids if the kids don't go to the doctors."

In many districts school-based services are provided through on-site school clinics. A variety of arrangements exist for operating these clinics, depending on local government structures, community support, and other factors. Some clinics are operated by the city public health department, others through contracts with health care providers, others by the district nursing and counseling staff. Depending on community opinions, clinics also have different policies on such issues as condom availability and family planning. Several participants felt strongly that whatever health care reform legislation is adopted at the federal level, it must include provisions for school-based services.

Urban districts have also implemented efforts to co-locate social services in the schools or to turn schools into community service centers that are open after hours and serve families and other segments of the community.

9. Funding and Resources

The Symposium made clear that integrated reforms do not come cheaply. Sometimes they require major investments in schools and communities, hiring of special staff, or "glue money" to foster collaboration.

Several possible funding sources were discussed, particularly in addition to federal and state grant funding, which are considered "soft" money that disappears after a specific period. An obvious approach is to ask different city agencies and service providers to devote some of their budget that would be used for youth services toward a comprehensive school-based effort.

Some states or cities have passed special human services or child services tax levies. This does not guarantee support for the schools, however; participants described situations in which schools did not see all of the promised funding, as it was funneled off to other purposes and institutions.

One way to institutionalize funding for the health services component of a comprehensive program is for the school system to become a Medicaid provider. This may be controversial or difficult in some communities or States, but many districts have done it successfully.

Volunteer and in-kind contributions should not be overlooked, including volunteer efforts of students. Businesses and corporations could also be asked for funding or for in-kind donations, such as office space and equipment.

In addition, school districts need to continue to work at the state and federal levels and in the courts to address funding inequities among districts and regions.

10. Federal Support

A consensus of the group was that legislative and regulatory support from the federal level is necessary for a lasting, national solution to school health and safety problems.

On the legislative front, there are some areas where a clear need for immediate action exists. One such area is gun control. Although participants did not always agree about the specific mechanisms, many felt that stronger and bolder gun control legislation was an essential part of a strategy to reduce violence in urban schools. As Mike Beard said regarding the recent passage of the Brady bill, "We simply cannot spend another decade working on legislation that will have minimal impact on the problem of gun violence in our society. It's time for us to take decisive action." Some options discussed were enacting an outright ban on the manufacture and sale of handguns, placing a tax on ammunition, instituting stricter licensing requirements, or allowing the Consumer Product Safety Commission authority to regulate handguns as safe product. Anti-crime legislation is another area to watch closely, advised Peter Edelman.

Health care reform is another timely area. According to Mr. Edelman, the President's health care reform package includes a major school-based child health initiative. Legislators may consider school-based health clinics a negotiable item, some participants warned, and strong urban advocacy is necessary to ensure that these provisions are included in a final package and that funding for them is provided without too many restrictions.

Participants were also advised of other pending Federal activities that could affect health and safety, including a proposal to require health screening in low-income schools as a condition for Chapter 1, ESEA funding, safe schools legislation, and efforts in USDA to revise Federal school lunch requirements to conform with the most recent national nutritional guidelines.

11. Larger Social Issues

What also cannot be ignored, participants agreed, are national efforts to influence factors that contribute to poor health and violence, including providing jobs, rebuilding an economic base in urban areas, helping to strengthen families, discouraging drug use, and fighting racism and discrimination.

School districts and educators can influence these areas on a professional or individual level through advocacy, networking with other organizations, becoming involved in causes on a volunteer basis, and other means. Andrew McGuire proposed a national summit meeting of all key players in the U.S. in the areas of child health and safety, to address issues outside the arena of the schools' expertise.

CONCLUSION

Improving the health and safety of urban children is a long-term effort, and will take more than a three or five year commitment. Speaker Andrew McGuire stressed that a long-term effort—from 20 to 100 years—is a more reasonable way of thinking. This does not excuse school people from taking immediate action, however; the short term is equally important, as urban educators who see illness and violence take a daily toll know all too well.

Despite the grimness of the statistics and the enormity of the problems, the Symposium offered frequent reminders that there is cause for optimism. Many participants described how their personal involvement with individual children led to happy outcomes: a youth letting go of gang membership, a student persuading a peer to seek counseling rather than commit suicide, a teacher helping a student understand how an unplanned pregnancy could foreclose her options. As Dr. Fairfax said, "Don't forget, urban kids can be resilient. We need to find out what makes kids resilient and instill it."